

Kentucky Aesthetic & Plastic Surgery Institute, PLLC
Alexander G. Digenis, MD
Brian P. Thornton, MD, Ph.D.
502.589.5544

Patient Information
(Please print legibly)

Today's Date: _____ **PLEASE BRING YOUR PHOTO ID**

Patient's Name: _____
First Middle Last

Prefix: Dr. Miss Mrs. Ms. Mr.

Address: _____
Street & Apt.# City State Zip

Social Security #: _____

Date of Birth: _____ Age _____

Marital Status: Single Married; Spouse's Name _____

Gender: Female Male

Home Phone # (____) _____,

Work# (____) _____ ext _____

Cell phone#: (____) _____

Email: _____

Emergency Contact:

-Name: _____,
First Last

-Relationship: _____

-Home Phone: (____) _____

-Work Phone: (____) _____

Physician/Nurse/Aesthetician you are seeing today: _____

Reason for Visit: _____

Referred by: Friend Internet Magazine/Newspaper/other

Physician (Name): _____

(Address and phone number): _____

Employment (Patient's or Insured's): _____

- Full-Time Full-Time Student Retired
- Part-Time Part-Time Student Other

Occupation: _____

Company or School: _____

Primary Health Insurance Company: _____

Policy# _____ Group # _____

Address for Claims: _____

Insurance Co. Phone #: (_____) _____

Copay? No Yes, \$ _____

Insured's Name _____ DOB: _____ /SS# _____

Secondary Health Insurance Company: _____

Policy # _____ Group # _____

Address for Claims: _____

Insurance Co. Phone #(_____) _____

Copay? No Yes, \$ _____

Insured's Name _____ DOB: _____ /SS# _____

May we contact you regarding upcoming or missed appointments? Yes No

How would you prefer to be contacted?: _____

Other Interests: (check as many as applicable)

- Botox Collagen Fillers Skincare Hair Laser Microdermabrasion

FINANCIAL POLICY & PATIENT RESPONSIBILITY

I understand that I am financially responsible for all charges incurred in this office. I authorize Dr. Digenis and/or Dr. Thornton to bill my insurance company directly, however, this does NOT transfer my financial obligation to my insurance company. I understand that this office will bill me for any balance left after my insurance company pays this office and all applicable write-offs have been taken or for the entire balance should my insurance company deny reimbursement. I acknowledge my financial responsibility for fees not paid by this assignment and agree to pay any late fees, collection agency fees and/or legal fees if my account becomes delinquent.

SIGNATURE _____ **DATE** _____

RELEASE OF INFORMATION

I hereby authorize the release of medical or other information acquired during the course of examination and treatment to Insurance Carriers or other Physicians.

SIGNATURE _____ **DATE** _____

SPECIAL PHOTOGRAPHIC CONSENT FORM

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case for purposes of education, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

Patient Signature

Witness Signature

Date

Medical History – Patient Intake Form

Name: _____ Date: _____

Welcome to the Kentucky Aesthetic & Plastic Surgery Institute. In order that we may know a little more about you, please answer the following questions about your Medical history.

1. Do you smoke? Y_____ N_____

If so how many packs per day: _____ How many years: _____

2. Please list any prescription or non-prescription medicines you take:

Name of Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you have any drug allergies Y_____ N_____ (please list if Yes)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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4. Do you or have you ever had any of the following conditions?

Diabetes	Y_____	N_____
High Blood Pressure	Y_____	N_____
Heart attack or Angina	Y_____	N_____
Tuberculosis	Y_____	N_____
Black Lung	Y_____	N_____
Asthma	Y_____	N_____
HIV	Y_____	N_____
Hepatitis/Jaundice	Y_____	N_____
Ulcers	Y_____	N_____
Cold sores/Fever listers	Y_____	N_____

5. Have you ever had any problems or disease in the areas below?

If YES Please Describe

Fever	Y_____	N_____	_____
Weight Loss	Y_____	N_____	_____
Eyes	Y_____	N_____	_____
Ears	Y_____	N_____	_____
Mouth	Y_____	N_____	_____
Throat	Y_____	N_____	_____
Lungs	Y_____	N_____	_____
Heart	Y_____	N_____	_____
Stomach	Y_____	N_____	_____
Bowels	Y_____	N_____	_____
Kidneys	Y_____	N_____	_____
Bladder	Y_____	N_____	_____
Liver	Y_____	N_____	_____
Extremities	Y_____	N_____	_____
Circulation	Y_____	N_____	_____
Skin	Y_____	N_____	_____
Muscles	Y_____	N_____	_____
Skeleton	Y_____	N_____	_____
Neurologic	Y_____	N_____	_____
Immunologic	Y_____	N_____	_____